Agenda Item 3
10/25/06 Meeting

Managed Risk Medical Insurance Board
September 20, 2006

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, M.P.H., Sophia Chang, M.D., M.P.H., Richard Figueroa,
Ex Officio Members Present:	Joe Munso, Warren Barnes (for Ed Heidig)
Staff Present:	Lesley Cummings, Denise Arend, Laura Rosenthal, Vallita Lewis, Janette Lopez, Dennis Gilliam, Mary Anne Terranova, Ernesto Sanchez, Sarah Soto-Taylor, Wendy Dodgin, Thien Lam, Willie Sanchez, Adrienne Thacker, Jamie Yang, Melissa Ng

Chairman Allenby called the meeting to order and recessed it for executive session. At the conclusion of executive session, the meeting was reconvened.

REVIEW AND APPROVAL OF MINUTES OF July 19, 2006 MEETING

A motion was made and unanimously passed to approve the minutes of the July 19, 2006, meeting.

Chairman Allenby acknowledged and welcomed Dr. Sophia Chang, recently appointed to the Board by the Senate. He also recognized Dr. Sandra Hernández, retiring member of the Board. Chairman Allenby thanked Dr. Hernández and presented her with an award recognizing her accomplishments and contributions to the Board.

Chairman Allenby next recognized Tom Williams, former Deputy Director of MRMIB, noting he has taken a position at the CA Department of Finance. Tom Williams was responsible for budget preparation and management for a number of years at MRMIB. Chairman Allenby thanked Mr. Williams for his efforts and presented him with an award recognizing his accomplishments and contributions.

Chairman Allenby then recognized Ms. Deborah Kelch, staff person to Assemblywoman Chan who authored AB 1971. He presented the Board's thanks to Ms. Kelch for her significant contributions and efforts to enact legislation that addresses MRMIP's funding deficit. He stated MRMIB would not have gotten as far without her leadership and expertise in health insurance. He presented her with an award acknowledging these efforts.

Ms. Kelch thanked the Board for its acknowledgment, saying that it was a morale boost. She also thanked the Board for its support during the legislative session; and complimented the Board's staff, an amazing, incredible group of people with dedication and commitment. She emphasized her ongoing commitment to obtaining coverage for medically uninsurable people who are unable to access coverage in the individual market and want to be in the program

Chairman Allenby asked if there were any questions or comments.

Richard Figueroa stated the $4 million is a start to getting people who are on the waiting list some health care insurance.

Gayle Miller of Blue Cross reiterated the words of Ms. Kelch and thanked Ms. Cummings and Ms. Rosenthal for their efforts. Blue Cross is extremely disappointed that AB 1971 did not pass and worked very hard for its passage. She informed the Board that given the losses Blue Cross is experiencing in GIP, Blue Cross has decided that beginning in 2008 it will terminate PPO coverage in MRMIP in any area where it has HMO coverage. Blue Cross would have liked to make this change for January 2007, but was unable to do so due to the short time frames for publishing the MRMIP handbook.

Mr. Figueroa thanked Blue Cross for its leadership role in advancing a solution for the medically uninsurable. There were battles among the carriers about the need for additional resources and the approach to obtaining them. Blue Cross stepped up to the plate at great political risk and financial risk.

Ms. Gotlieb expressed how deeply concerned the Board is about having to maintain a waiting list and emphasized that the Board will be there to provide its support in the next legislative session.

Note: Agenda items were taken out of order at this meeting.

SAN FRANCISCO HEALTH ACCESS PROGRAM PRESENTATION

Dr. Sandra Hernández, CEO of the San Francisco Foundation, made a presentation to the Board describing the plan recently developed in San Francisco to provide a medical home to San Francisco's adult uninsured residents. She made reference in her presentation to an executive summary of the plan which was distributed to Board members and the public.

Mayor Gavin Newsom created the Universal Health Council (UHC) to develop a proposal for increasing access to health services for uninsured San Franciscans. Dr. Hernández co-chaired this effort with Lloyd Dean, the CEO of Catholic Health Care West.

The 44 UHC members are a diverse group, including representatives from the health care industry, business, labor, advocacy organizations, philanthropy, research and other disciplines. It was designed as a collaborative effort to develop the parameters of a program for providing health care to an estimated 82,000 uninsured San Francisco residents. UHC members were unanimous in supporting the approach developed in its meetings and submitted its report to the Mayor on June 23, 2006.

Central to the context of the effort was the UHC's agreement that expanding access would require participation from all interested parties – individuals, employers, public and private health care providers and government.

The approach is not one of providing insurance coverage. Rather, it uses the San Francisco Health Plan and its wide array of community providers to offer a package of comprehensive health services that emphasize prevention, choice of providers, quality performance accountability and affordability. Thus, residents would not have access outside of San Francisco, but would, in San Francisco, have a medical home and coordinated medical care rather than accessing care through an inefficient, costly, episodic, fragmented delivery system. Another decision point in deciding against provision of insurance coverage was the need to ensure that the program could continue to make use of funding from categorical programs (such as disproportionate share hospital payments under Medi-Cal) that provide public dollars for many services used by this population

The development of the approach was data driven which was an important element of its eventual success. The group reviewed data on the demographics of the uninsured and where they received care presently. They found that 56% of the uninsured were employed and that 69% had used the safety net charity care system in 2004. Of these, most (76%) received outpatient services, 20% received emergency services and 4% received inpatient services. The data caused UHC to conclude that the program must ensure sufficient access to outpatient-based primary and preventive care services.

Another big issue was how to redirect some of the funds the City/County already spends for safety net care to the new program. The city/county spends $100 million (general fund) subsidizing health care in the safety net systems.

The committee estimated the cost of providing health services to the uninsured via a coordinated system was around $ 200 million. It will be financed by a combination of employer, individual, City/County contributions and other public sources.

Dr. Hernández went on to discuss the process that led to UHC's agreement on an approach. The Mayor provided a short time frame for its development (100 days). A member of the Board of Supervisors had introduced an ordinance requiring employers to contribute for their employees' coverage. Portions of the

business community were concerned about the ordinance. UHC discerned that the ordinance would result in coverage for 18,000 of the 82,000. There was a very strong sense in the business community that business owners should be part of financing the plan. The only debate was how business would participate. UHC did not determine how to achieve business' financial contribution.

UHC wanted to assure that program participants have good access to providers and concluded that it was essential to pay providers at rates that would allow for their participation. The program intends to pay providers at Medicare rates.

Chairman Allenby asked if there were any questions or comments from the Board. Dr. Crowell complimented Dr. Hernández on providing a wonderful explanation of the San Francisco Health Access Plan. She asked about labor's participation in the process. Dr. Hernandez indicated that labor was a very active participant. Chairman Allenby asked Dr. Hernández to discuss whether the plan called for used of managed care. Dr. Hernández indicated that the purpose was to assure that a person had a medical home and access to coordinated, necessary care. Utilization management is important, but the most important aspect is tracking health outcomes and measuring quality. Dr. Crowell asked whether the plan included pharmaceutical benefits. Dr. Hernández stated they are included. Dr. Crowell asked if there were any limitations. Dr. Hernández replied that there will be something that will mirror a formulary.

Chairman Allenby asked if there comments from the public.

Leona Butler, CEO of the Santa Clara Health Plan, expressed gratitude for the work that has been done. She asked for a further explanation of the redirection of safety net funds from hospitals to the system of care, wondering how providers will deal with those who show up seeking treatment. Dr. Hernández replied that San Francisco has worked for some years to ensure that hospitals (particularly UCSF) are not the last resort for health care. The finesse under the new system will be to figure out how to move chronic care out of the emergency rooms and into the system of care. However, the $100 million now being spent in the safety net cannot just be taken away without domino effects. The challenge is to create a culture change for patients.

Chairman Allenby asked if there were any additional questions or comments. There were none.

PACADVANTAGE PRESENTATION

John Grgurina, President of PacAdvantage gave a presentation to the Board on the upcoming closure of PacAdvantage's health insurance operations. PacAdvantage, a purchasing pool for small employers, was developed and operated by MRMIB prior to its privatization in 1998. When PacAdvantage

ceases operations, 6200 employers (with 116,000 covered lives) will have to find new coverage.

Mr. Grgurina described the circumstances which led the PacAdvantage Board to decide to cease operations. He went on to detail the steps taken to assure that members would have a smooth transition to other coverage, noting that under state law, small employers have a right to guaranteed issue coverage. He recounted the contributions that the pool had made in changing the small employer insurance market, particularly noting that it had pioneered the provision of employee choice of plans as well as developing a cutting edge tool to help employees choose the plan best for them.

Mr. Grgurina then proceeded to discuss two lessons to be learned from the pool's 13 year history.

1. An unsubsidized voluntary purchasing pool will not significantly lower health care costs or reduce the number of the uninsured. Plans with large market shares chose not to participate, making the pool less attractive for many brokers and employers. Those plans that did choose to participate still preferred getting the entire small employer group rather than the portion of employees that might choose them in an employee choice environment. This meant that the plans did not offer their best prices to the pool—but rather in the market. Plans were concerned about risk distribution in the pool and while Pac Advantage administered a financial mechanism to balance risk across plans, the perceived weakness of the process discouraged plan participation. And lastly, because a plan's business in the pool was small compared to its overall small group membership, the pool wasn't large enough to negotiate lower costs.
2. Pools can be part of a solution in addressing states' health care problems by administering subsidized programs for the uninsured, providing health plan choices and consumer information. Small employers do want to give their workers a choice of health plans and pools are an excellent way to do that. Pools are also well-positioned to offer consumers tools for making informed decisions on the right coverage for them. Pools are effective and efficient vehicles for administering subsidized coverage. However, they must operate in an environment where large plans participate and offer rates comparable to those in the marketplace.

Chairman Allenby asked if there were any questions or comments. Ms. Gotlieb commented that the PacPlan chooser sounded like a great product and asked whether it will be available after PacAdvantage closes its doors. Mr. Grgurina stated that the Pacific Business Group on Health, PacAdvantage's parent company, is very involved in development of consumer information and tools and will continue its work in this area.

Chairman Allenby recalled that when the Board first established the pool, a number of plans and agents advocated against having employee choice, arguing that it would create risk concentration problems. He asked whether PacAdvantage would have had a better chance if it had used employer choice of plan instead. Mr. Grgurina stated that the employer choice model did not work in the Florida purchasing pools. PacAdvantage had recently begun offering a very popular paired choice product which offered employers two plans for their workers. Sales in June were the largest sales month in the pool's history –but this was not enough to save it.

Chairman Allenby asked whether PacAdvantage would have been more viable if it used HMO's exclusively (as opposed to also offering a PPO). Mr. Grgurina stated this would have been better for risk selection but bad for sales. Employers want a PPO for themselves, particularly in Southern California.

Dr. Chang asked whether employers changing insurers will be able to get rates similar to those they had in the pool. Mr. Grgurina stated that many will get lower rates, but that they will lose the opportunity for choice, particularly the very small employers. Dr. Chang then asked what was in store for employers carrying higher costs. Mr. Grgurina noted that under the rules of the small group insurance market, carriers are limited in their ability to charge higher risk employers more than lower risk.

Mr. Figueroa commented that it is hard to lose a valuable program like this. PacAdvantage has been exemplary in the way it has handled the situation.

Chairman Allenby asked if there were any more questions or comments. There were none.

STATE LEGISLATION

State Legislative Summary

Chairman Allenby noted that the legislature had completed the second year of the two-year legislative session. In the interests of time, staff will present the legislative summary and more detailed discussions of SB 1702 and SB 437 at the October Board meeting. Information on these items is in the Board members' packets.

AB 1971 (Chan)

Ms. Cummings provided the Board with an overview of the events in the last hours of session that led to the death of AB 1971. She briefly reviewed the components of the bill as it last appeared in print and reminded the Board that a written description was in their packets. She drew the Board's attention to an article in their packets on a Commonwealth Fund study that found that 89% of people who applied for insurance were rejected for medical reasons or were offered rates that they could not pay

SB 1702 (Speier and Cox)

Ms. Cummings stated that, with the death of AB 1971 in the last hours of session, the Legislature quickly enacted a separate piece of legislation, SB 1702, that extended GIP for three additional months (through December 2007) and appropriated an additional $ 4 million in state funds to cover people on the waiting list. Ms. Cummings asked for guidance from the Board on how many people to enroll with these funds. The average MRMIP subscriber is enrolled for 30 months. When MRMIP received supplemental appropriations in the past, the Board had determined that the funds had to be set aside for the full case cost of a subscriber. However, now funds have been provided with the anticipation that a larger funding solution will be enacted next year. She presented a document developed by PricewaterhouseCoopers (PWC) which estimated the number of subscribers who could be enrolled if the Board set aside funds for the full 30 months of case costs, for 24 months or for 12 months. The most conservative course was to set aside for 30 months, but this would significantly reduce the number of people that could be enrolled (1,279 people for 12 months, 640 for 24 months and 512 people for 12 months).

Mr. Figueroa advocated enrolling in accordance with the 12-month version so that people were off the waiting list as quickly as possible. The issue of MRMIP funding will be visited again in the legislature next year and staff will need to work hard for a resolution of the issue.

Joe Munso asked what would happen if the Board took this action and the legislature does not provide continued funding. Ms. Cummings stated the Board would face some difficult issues and would have to impose hard freezes and possibly disenroll subscribers.

Mr. Figueroa stated that if there is no legislative solution next year, MRMIP faces an even bigger problem.

Chairman Allenby stated the staff had received the sense of the Board to fund based on 12 months of coverage. He asked staff to come prepared at the next meeting to discuss MRMIP's funding needs assuming an uncapped program

Chairman Allenby asked if there were any more questions or comments. There were none

SB 437 (Escutia)

Ms. Cummings stated the Governor signed SB 437 yesterday (September 19). She quickly reviewed its provisions, noting that implementation of its provisions calling for operational changes was contingent on future appropriations. She noted that a summary of the enrolled version of SB 437 was in the Board packet.

The new law:

- Requires MRMIB to implement by January 1, 2008 a process by which families can self-certify income at the time of annual eligibility review.
- Changes the current MC to HFP bridge program by eliminating the one-month time limit of the bridge and providing presumptive eligibility until a final HFP determination is made. This is for children who were receiving no-cost MC but at annual review are no longer eligible for no-cost MC and appear to be income eligible for HFP.
- Expands accelerated enrollment available to children who apply at the county welfare departments for MC and HFP and appear to be income eligible for HFP. Counties would provide presumptive HFP eligibility for such children. Presently, only children determined eligible for the MC Share-of Cost Program are eligible for accelerated enrollment.
- Requires MRMIB and DHS to design and implement policies and procedures for an automated enrollment gateway system that will allow children applying for WIC to obtain presumptive eligibility for MC and HFP and simultaneously apply for enrollment into MC or the HFP. This would require modification of the current WIC application.
- Authorizes DHS to implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without having to submit documentation of assets and income

AWARD OF ACTUARY CONTRACT

Prior to hearing this issue, Chairman Allenby administered the oath of office to Dr. Chang.

Dennis Gilliam presented a report to the Board describing the solicitation and selection process for a new actuary contract, and making recommendations on winning contractors. He reminded the Board that the solicitation package was approved by the Board on May 17, 2006 and had included the possibility of awarding a contract to more than one contractor.

The Board received six proposals on June 10, 2006, the final bid date. Bids were received from AON, Deloitte Consulting, LLP, Lewis and Ellis Actuaries and Consultants, Mercer Government Services Consulting, Milliman Consultants and Actuaries, and PricewaterhouseCoopers, LLP. This was a record number for

actuary procurements. Mr. Gilliam described how the bids were assessed and then advanced the staff recommendation to contract with PricewaterhouseCoopers and Mercer.

Mr. Gilliam communicated to the Board that the resolution placed before them does not reflect a final award. However, because there are some loose ends that need to be resolved this morning over the contract language with one of the awardees, the resolution presented to the Board for approval authorizes the Executive Director to complete the negotiations and make the final awards.

A motion was made and unanimously passed to approve the authorization.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

UCSF Study on HFP Approach for Coverage of Seriously Emotionally Disturbed Children (SED)

MRMIB relies on county mental health departments to provide treatment to children diagnosed with Serious Emotional Disturbances (SED). This is referred to as the SED carve out. Basic mental health services are provided by a child's HFP health plan. At MRMIB's request, The Endowment funded the University of California at San Francisco to assess the efficacy of the carve out in meeting the needs of HFP children with SED. The current year budget provides funding for a similar review of the basic mental health services provided and substance abuse services provided by plans.

Chairman Allenby introduced Dr. Dana Hughes and Dr. Mary Kreger of UCSF who presented their findings on the SED Carve-out. The report will be available on MRMIB's website www.mrmib.ca.gov.

They discussed what is known about the prevalence of SED's, how the process is intended to work for HFP children, and what is known about the referral and treatment rates for HFP children. They described the process they used to obtain feedback on the system, noting that they had conducted key informant interviews in 10 counties. They had also wanted to conduct focus groups with parents of children with SED's but had been unable to identify a sufficient number to participate. Thus, they conducted interviews with a selected number of parents.

Drs. Hughes and Kreger next identified the challenges that had related to the design of the delivery system, noting that a number of these were beyond the ability of MRMIB to control. Next, they presented findings on how to improve the delivery of services. These included: Increasing the understanding of the health plans and county mental health departments (CMHD) on how the system is supposed to work; maintaining an up-to-date list of plan SED liaisons and county liaisons; creating a central source for dispute resolution; clarifying in the plan/county MOU which entity is responsible for coverage when a county has a

waiting list; resolving the issues with county reimbursement for SED medications, and work with the Prop. 63 process to identify screening tools for early identification and intervention on mental health issues.

Chairman Allenby asked if there were any questions or comments from the Board. Mr. Munso asked why schools didn't seem to have an active role in the process. Chairman Allenby noted that coordination with schools is logistically challenging because there are over 1,100 school districts. However, it is important and something to be looked into. Dr. Hughes noted that the report focuses on the relationship between plans and counties. She acknowledged that schools play a major role in providing mental health services to children. Some school districts communicate with counties and coordinate SED information but many do not. The report identifies this as an area for future research.

Dr. Crowell thanked Drs. Hughes and Kreger for the research and work on the report. She disagreed with the characterization of the schools' role and stated that Jack Campana (HFP Advisory Chair) would also if he were in attendance at the meeting. She also disagreed with Dr. Hughes's statement that counties were not including children in their MHSA (Proposition 63) plans. She thought the report expanded on what has been known about the SED carve-out, but expressed concern that the data on which it is based is limited by small groups of informants. Dr. Crowell reminded the Board that this had been the first of three planned studies on the subject of mental health, and the second study will be on how well the plans are assessing and providing basic mental health services. She expressed gratitude that MRMIB had received a couple of positions to work on mental health issues, noting that resources available for this purpose in prior years had been lost in budget cutbacks. Prior to those cutbacks, MRMIB staff and the county mental health directors had been actively engaged. She also stated that MRMIB should modify its plan contracts to require them to have a liaison and keep MRMIB informed of the name of the liaison.

Ms. Gotlieb asked Dr. Hughes and Ms. Cummings why MRMIB should have to be in the middle of plans and counties in ensuring that they maintained and shared lists of liaisons. She thought this could result in a lot of work for staff given the number of counties and plans. Dr. Hughes replied that maintaining the list is an onerous job but one that had to be centralized. MRMIB could be a resource.

Chairman Allenby called for questions and comments from the public.

Leona Butler, CEO of Santa Clara Health Plan, suggested that children would receive better services if the Board eliminated the carve-out and placed the whole responsibility with health plans. She noted that her plan takes care of the mental health needs of children in the Healthy Kids program without a carve-out. Relying on counties for these services is particularly problematic given that they are facing serious cuts in mental health services. Dr. Crowell commented that plans would then have to liaison with schools and there are different legal

requirements. Ms. Butler stated they already do this with their Healthy Kids Program

Pat Ryan of the County Mental Health Directors Association (CMHDA) questioned the statement that some of the 10 counties reviewed stated they had not included SED children in their MHSA plans. The county MHSA plans do have a place for SED children, so it is hard to understand what this statement in the report means. CMHDA has reviewed the recommendations of the report and are generally in agreement with them. Communication is critical and they remain committed to working with the Board and staff. Ms. Ryan agreed that the counties' limited financial resources create problems for delivery of mental health services. She noted that Proposition 63 had not been a financial panacea for the mental health system. Santa Clara County has to reduce its mental health budget by $34 million and will receive only $12 million from Proposition 63. She urged a resolution of the problem that precludes county mental departments from obtaining FFP for prescriptions written for HFP children. She acknowledged a need to improve the referral systems and emphasized the CMDHA remains committed to working with the Board and staff. Dr. Crowell commented that the Board too is in substantial agreement with the recommendations. There are some important areas for follow up.

Chairman Allenby asked if there were any additional questions or comments. There were none.

HFP regulations to implement 2006 Health Trailer Bill Language-first draft

Sarah Soto-Taylor presented the first draft of regulations to implement statutory changes made in the budget Trailer Bill language. The regulations will be presented at the next meeting for adoption.

Chairman Allenby asked if there were any questions or comments.

Ms. Gotlieb inquired what the process would be if an applicant fails to specify plan choices in the application. Ms. Soto-Taylor replied that the administrative vendor will contact those families who have not made plan choices and attempt to get them to do so. If the AV is unsuccessful, it will proceed to process the application and assign the subscriber to a plan. For health plans, subscribers will be defaulted to the Community Provider Plan if one is available in their area. If one is not—and for dental and vision plans, the AV will use a random assignment process. However, subscribers are allowed to change plans with the first 3 months of enrollment.

2007 Open Enrollment Process

Janette Lopez reviewed with the Board the options for the conduct of the HFP open enrollment process presented at the prior Board meeting. Since that

meeting, staff solicited comments from the public. There was a high response to replying to the questionnaire. She then presented an updated document that identified the options and their pro's and con's and summarized the feedback received. After consideration of the input, staff decided to proceed with Option 1 for the 2008 open enrollment: Sending a postcard to applicants instead of a pre-printed OE packet. Major considerations in selecting this option were: time is getting short to implement any option and the post card approach is the simplest to do quickly, and addresses carriers concerns about the loss of continuity with the option to allow plan changes at will. She recalled that Dr. Hernandez had expressed concerns about not sending full OE packets to every household because then there would be no reliable means of communicating plan quality information. Staff will consider providing such information in welcome letters (subscribers can change plans in the first three months of enrollment) and informing subscribers on the OE postcard of the availability of plan quality information on the website.

Dr. Crowell asked about the option that combines OE and AER. Ms. Lopez replied that with the extensive efforts MRMIB is making to increase retention at AER, she thinks it inadvisable to distract families with OE materials. Ms. Cummings reminded the Board that the postcard option does not reduce the OE workload of the AV and staff as it continues to concentrate OE into one short period. It will reduce printing costs and thus save trees.

Ms. Gotlieb asked about the basis of plan concerns about continuity of care as a legitimate issue about OE: If an enrollee is happy with his or her plan, why would the enrollee change? If they are not happy, why should they not change?

Chairman Allenby asked if there were any other questions or comments. There were none.

Review of draft plan contract amendments

Denise Arend presented to the Board the first draft of plan contract amendments for the benefit year beginning July 2007. These will be finalized at the next meeting. She reviewed each of the proposed contract changes. Dr. Crowell suggested adding provisions requiring plans to have a mental health liaison.

Chairman Allenby asked if there were any additional questions or comments. There were none.

Community Provider Plan (CPP) Process

Carolyn Tagupa presented an updated issue paper concerning the Community Provider Plan (CPP) designation process. She had presented the first draft of the paper at the July Board meeting.

Staff had developed the issue paper to address the concerns of various plans with the CPP process. Plans commented on the recommendations in the first draft during the period between Board meetings. The paper presented at this meeting details plan comments and makes final recommendations on the process. Due to timing concerns, staff recommended that any changes take effect for the benefit year beginning July 2008.

Hospital Issues. Staff recommends that MRMIB continue to allow credit for out-of-county hospitals when they provide services to qualifying children who reside outside of the county where the hospital is located, because this method recognizes hospitals that give care to Medi-Cal children, based on the number of services provided. Staff recommends retaining the current method of generating the T&SN Hospital List, because the DHS method recommended by some plans does not achieve the goals or intent of the CPP designation process.

Clinic Issues. For benefit year 2008, staff recommends including Provider Type 15 (Community Hospital-Based Outpatient Clinics) in the T & SN Clinic list but modifying the scoring method for clinics by dividing the current clinic score weight of 45 percent in half, and thus applying a 22.5 percent weight using the current method and basing the other 22.5% on the number of services provided. Clinics that provided fewer than 15 services during a one-year period will be excluded from the T & SN Clinic List. Staff recommends alternate methods be developed for removing duplicates from the list and working with plans to ensure that their ability to match their providers with the T & SN Clinic List is not compromised. Staff recommends no change in the method currently used to generate the T & SN Clinic List in regards to methadone and optometry clinics, because there is no available method for isolating these types of clinics.

Chairman Allenby asked if there were any questions. The Board acknowledged the good staff work on this process.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

AIM regulations to implement 2006 Health Trailer Bill Language and State Supported Services (first draft)

Ms. Soto-Taylor presented the Board with the first draft of the aforementioned document, discussing each proposed change to the regulations. Staff will bring the regulations back to the Board at the next meeting for adoption.

Chairman Allenby asked if there were any questions or comment. There were none.

MAJOR RISK MEDICAL INSURANCE PROGRAM (UPDATE)

New Subscriber Premiums

Ms. Arend presented a document prepared by PricewaterhouseCoopers that details the changes to subscriber premiums for the benefit year beginning January 1, 2007. Premiums increased 2.75% overall from last year's premiums.

Chairman Allenby asked if there were any questions or comments. There were none.

Reports Put Over To Next Meeting

Because the special reports on this meeting's agenda caused the meeting to last well past its scheduled ending point, the following reports were put over to the next Board meeting.

- HFP Enrollment and Single Point of Entry (SPE) Reports
- HFP Administrative Vendor Performance Report
- HFP Enrollment Entities/Certified Application Assistants (EE/CAA) Reimbursement Report
- HFP Appeals Program Review Workload Update
- HFP 2006 Open Enrollment Results
- HFP Advisory Panel Update
- CHIM: Healthy Families Buy-In Update (CCS/Reinsurance Option**)**
- AIM Enrollment and Financial Reports
- MRMIP Enrollment and Financial Reports

The meeting was then adjourned.